

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022621

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1566

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 5 1963

VS 300  
Rev. 4/59

1 4000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis County</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>    </u>                          |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Koch Mo.</u>   |   | Length of stay in 1b <u>452 days</u>  | c. CITY OR TOWN <u>St. Louis</u><br>Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Robt. Koch Hospital</u>  |   | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>3505<sup>a</sup> Shenandoah Ave.</u><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Kathleen M Johnston</u>   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>Mar 12 1963</u>  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-29-23</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Huswife &amp; Dictaphone OPER.</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Trucking Ind</u>  | 9. AGE (last birthday) <u>29</u><br>IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.  |
| 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Mo.</u>  |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |   |
| 13a. FATHER'S NAME<br><u>Lester Truey</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Marcella Jane</u>   | 14. NAME OF HUSBAND OR WIFE<br><u>James Johnston</u>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates)<br><u>    </u>  |   | 16. SOCIAL SECURITY NO. <u>3</u>  | 17. INFORMANT<br><del>XXXXXXXXXX</del> <u>James Johnston</u><br>Address <u>3505<sup>a</sup> Shenandoah</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple CVA's</u>  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Lupus</u>  |   |   |   |
| DUE TO (c) <u>014.2</u>  |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |   |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION  | COUNTY  | STATE   |
| 21. I attended the deceased from <u>4-1-63</u> to <u>5-12-63</u> and last saw her/him alive on <u>5-11-63</u><br>Death occurred at <u>11</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>Maurine J. Cogle M.D.</u>   |   | 22b. ADDRESS<br><u>4441 Flora Pl.</u>   | 22c. DATE SIGNED<br><u>5-13-63</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  | 23b. DATE<br><u>5/15/63</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SS Peter &amp; Paul</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Mo.</u>   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>E.J. Schnur 3125 Lafayette</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>5-13-63</u>  | 26. REGISTRAR'S SIGNATURE<br><u>John C. Murphy M.D.</u>   |

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

STATE BOARD OF HEALTH

*[Handwritten signature]*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *[Handwritten Signature]* \_\_\_\_\_

Licensed Embalmer No. *3653*

P. O. Address *[Handwritten Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

*[Handwritten mark]*